HEALTH INSURANCE PREMIUM VERIFICATION

TO: (Name and address)
_____
_____
_____

DATE: _____
TELEPHONE #: _____
FAX #: _____

APPLICANT/PARTICIPANT NAME: _____
SOCIAL SECURITY #: _____

FROM:

The individual named directly above is an applicant/tenant of the Federal Housing Tax Credit Program, Federal regulations require that we must verify income in order that the anticipated gross income for the next twelve months may be calculated. The information provided will remain confidential to satisfaction of that stated purpose only. Your prompt response is crucial and would be greatly appreciated.

Sincerely,_____

Project Owner/Management Agent

RETURN THIS FORM TO:

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All medical expenses which are described below may be listed as allowances to help reduce my rental cost.

I hereby authorize release of any information requested regarding my income, assets, and allowances.

_____
Applicant/Resident Signature

TYPE OF POLICY	POLICY NUMBER	ANNUAL PREMIUM	DEDUCTIBLE	% PAID AFTER DEDUCTIBLE MET
1.				
2.				
3.				

Does the policy have prescription coverage? YES NO *(circle one)*

If yes, what is the deductible for prescriptions? $_____

_____ _____
Signature of Person Verifying Information Telephone Number

_____ _____
Title Date